World Health Organization

European Region

Child and youth mental health in the WHO European Region

Status and actions to strengthen quality of care

Abstract

For the first time WHO Regional Office for Europe brings together all of data available at the Regional level on child and youth mental health. One in seven children and adolescents aged 0–19 years old lives with a mental health condition, and this number is increasing over time. Females are particularly affected with one in four females aged 15–19 years old living with a mental health condition. Suicide is the leading cause of death for young people aged 15–29 years old, and males are three times as likely to die by suicide. Everyday environments such as schools and online spaces are not adequately supporting the mental health of children and young people (CAY). One in five countries lack policies to support CAY mental health. Community CAY mental health services are lacking in one in four countries, and the mental health treatment received by CAY varies greatly across the Region. There is a clear need for action to better support the mental health of CAY. Previous recommendations are confirmed, and nine actions are proposed to strengthen and standardise the quality of care for CAY living with mental health conditions across the Region.

Keywords

MENTAL HEALTH, CHILD, ADOLESCENT, QUALITY OF HEALTH CARE

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World Health Organization

European Region

Child and youth mental health in the WHO European Region

Status and actions to strengthen quality of care

Contents

Foreword

Mental health is the foundation of well-being, learning, and belonging. Yet far too many young people continue to struggle with mental health issues in silence, facing social, economic, digital, and environmental challenges without support.

Across the WHO European Region, more than 30 million children and adolescents – one in seven – live with a mental health condition. Suicide is the leading cause of death among young people aged 15–29 years. One in ten young people report signs of problematic social media use. Approximately half are exposed to adverse childhood experiences and one in five report no social support. The stressors they face are both new and deeply familiar.

Behind these figures are millions of stories – stories of distress, but also of courage and resilience, and a reminder that the future health and prosperity of our countries depend on how well we care for our youngest generations.

Child and adolescent mental health is a top priority under both the second European Programme of Work, and the WHO-UNICEF strategy for child and adolescent health and well-being in the WHO European Region 2026–2030.

This landmark report brings together, for the first time, comprehensive data and evidence on the mental health of children and youth across 53 Member States. It documents not only the growing burden of mental and substance-use conditions but also the gaps in response. It is deeply concerning that one in five countries lack policies or plans for child and adolescent mental health, and services remain concentrated in hospitals rather than in communities where young people live, learn and play.

Going forward, we need to work together to strengthen the quality of care for child and youth mental health. This includes ensuring a 'mental health in all policies' approach to include mental health across education, social welfare and law enforcement governance, strengthening data collection and research, and better supporting the capacity of our front line workers to deliver high-quality care for this population.

We now have the data and tools to act. This report not only presents the current state of child and youth mental health across our Region, but also outlines proposed actions to help countries improve the quality of care and close existing gaps. Improving quality of care is not just a technical ambition – it is a moral and human imperative.

For every number in this report there is a child, a family, a community – and an opportunity for change. Each and every child matters. By investing in their mental health today, we invest in a healthier, fairer, and more resilient Pan-European region tomorrow. It is imperative to make this vision a reality.

Dr Hans Henri P. Kluge
Regional Director
WHO Regional Office for Europe

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Abbreviations

ACE	adverse childhood experience
CAMH	child and adolescent health
CAY	children and young people
CAYMH	child and youth mental health
COVID-19	coronavirus disease
DALY	disability-adjusted life year
QoC	quality of care

Glossary

Adolescent is used to describe an individual aged 10–19 years.

Caregiver refers to any parent, family member, legal guardian or individual who has a defined caring role for the child or young person.

Child is used to describe an individual aged 0–18 years.

Child and adolescent mental health workforce refers to the group of professionals working in child and adolescent mental health, including psychiatrists, psychologists, occupational therapists, social workers and other specialised child and adolescent mental health workers.

Child and adolescent inpatient services refers to specialized facilities that provide inpatient care and long-stay residential services for children and adolescents with mental health conditions, typically either through mental hospital or psychiatric units in general hospitals.

Child and adolescent psychiatrist is a medical doctor who has had a least two years of specialized training in child and adolescent psychiatry at a recognized teaching institution.

Community-based outpatient facility refers to a facility that manages mental health conditions and related clinical and social problems, does not provide overnight accommodation and is based in the community.

Early intervention services for specific child and adolescent mental health conditions aim to provide prompt detection and evidence-based care to children and adolescents presenting with a first or early episode of a mental health condition to prevent escalation; for example, early intervention services for psychosis or eating disorders.

Mental health is a state of mental well-being that enables people to cope with the stresses of life, realize their abilities, learn well and work well and contribute to their community. It is an integral component of health and well-being that underpins our individual and collective abilities to make decisions, build relationships and shape the world we live in. Mental health exists on a complex continuum, which is experienced differently from one person to the next, with varying degrees of difficulty and distress and potentially very different social and clinical outcomes.

Mental health conditions include mental disorders and psychosocial disabilities as well as other mental states associated with significant distress, impairment in functioning or risk of self-harm. People with mental health conditions are more likely to experience lower levels of mental well-being, but this is not always or necessarily the case. In this report, the term “mental health condition” is used to refer to a “mental disorder”.

Mental health in-patient community residential facility refers to a non-hospital community-based mental health facility providing overnight residence for people with mental health conditions.

Mental health law is the specific legal provisions that are primarily related to mental health. They typically focus on issues such as quality care and services, civil and human rights protection, professional training and service structure.

Mental health outpatient facility is an outpatient facility that provides support to people with mental health conditions and related clinical and social problems.

Mental health policy is an official statement of a government that conveys an organized set of values, principles, objectives and areas for action to improve the mental health of a population.

Mental health promotion and prevention works by identifying the individual, social and structural determinants of mental health, and then intervening to reduce risks, build resilience and establish supportive environments for mental health. Interventions can be designed for individuals, specific groups or a whole population. For child and youth mental health, it can be achieved by policies and laws that promote and protect mental health, supporting caregivers to provide nurturing care, implementing school-based programmes and improving the quality of community and online environments. School-based social and emotional learning programmes are among the most effective promotion strategies for countries at all income levels.

Mental health services refer to facilities that deliver mental health care and interventions that aim to protect or promote mental health, or treat mental health conditions across the continuum of care. Services can becommunity-based (in health care, community mental health services or beyond the health sector), in residential settings or in mental hospitals.

Mental hospital refers to a specialized hospital-based facility that provides inpatient care and long-stay residential services for people with mental health conditions.

Other specialized mental health worker is a health or mental health worker who possesses training in health care or mental health but does not fit into any of the defined professional categories (e.g. psychosocial counsellors, auxiliary staff).

Psychiatrist is a medical doctor who has had a least two years of specialized training in psychiatry at a recognised teaching institution.

Psychologist is a professional who has completed formal training in psychology at a recognized, university-level school for a diploma or degree in psychology.

Quality improvement initiative describes the action of any person working to implement iterative, measurable changes to improve the quality of a defined area or aspect.

School-based mental health services refers to mental health support provided in a school setting (e.g. counsellors, group programmes).

Substance use conditions is a broad term covering substance use disorders. It also covers substance use associated with significant distress, impairment in functioning or risk of self-harm.

Young people usually refers to people between the ages of 15 and 24 years old; however, some datasets were only available for those aged 15 to 29 years – as such, the definition has been expanded to 29 years for this report.

Youth usually refers to individuals between the ages of 15 and 24 years old; however, some datasets were only available for those aged 15 to 29 years; as such, the definition has been expanded to 29 years for this report.

Executive summary

For the first time, the WHO Regional Office for Europe brings together the latest data on child and youth mental health (CAYMH) at the regional level. It outlines population needs, trends and what support is available in response, including governance, workforce, services and quality of care (QoC). Existing recommendations are confirmed, and nine further actions are proposed to improve the QoC.

The mental health of children and young people (CAY) is worsening over time. Over 30 million – approximately one in seven – children and adolescents aged 0–19 years old are living with a mental health condition across the Region. The impact is so high that mental health and substance use conditions are the leading cause of disease burden for those aged 0–29 years. Prevalence increases with age, with over one in five (22%) of adolescents aged 15–19 years old living with a mental health condition. Females are more impacted than males, and one in four females aged 15–19 years old lives with a mental health condition. The prevalence of mental health conditions in CAY aged 0–19 years old has increased by one third (34%) since 2010, and the prevalence of CAY living with anxiety conditions has almost doubled in this time (increased by 86.66% since 2010).

Data on adolescent mental health and well-being shows a decline since 2018 with females, those from low socioeconomic backgrounds and older adolescents being more likely to report negative outcomes. One third of adolescents report experiencing nervousness, irritability and difficulties getting to sleep, and one in four reported feeling low.

Suicide is a major public health concern. It is a leading cause of death across all age groups and the leading cause of death for young people aged 15–29 years old. For CAY under 30 years old, males are three times more likely to die by suicide than females. Positively, suicide rates have decreased since the year 2000.

Potential emerging issues for adolescent mental health and well-being include online behaviours and changing substance use behaviours. An increase in problematic gaming and problematic social media has been observed since 2018 with one in ten reporting these behaviours, and a rise in adolescents using e-cigarettes or "vaping" has been seen. Alcohol is the most used substance amongst adolescents, followed by e-cigarettes.

Environments profoundly impact the mental health and well-being of CAY and contain stressors for many. Approximately half of CAY are exposed to adverse childhood experiences, school satisfaction is decreasing over time, one in five reported no social support and one in seven experienced cyberbullying online. The coronavirus disease pandemic disrupted daily routines and impacted adolescents differently, with equal proportions reporting a negative, neutral and positive impact on their mental health and well-being. Just under half of caregivers of children aged 6–9 years old reported a negative effect of the pandemic on their child's mental health and well-being.

Despite these compelling statistics, governance for CAYMH is lacking. One in five countries lack a policy or plan for child and adolescent mental health (CAMH), and data were lacking or nonexistent on CAMH multisectoral policies and plans and how legislation protects the rights of children and adolescents with mental health conditions. However, progress has been made over time, with more countries reporting the existence of a policy or plan for CAMH from 2016 to 2021, and again from 2021 to 2024.

All countries report the existence of CAMH services in hospitals and inpatient settings, one in four lack services in community outpatient settings, and two-thirds lack school-based services. This highlights the need for more community based services. Existing data showed high variability and inconsistencies in the number, type and use of CAMH services across the Region. More data is needed on the types of services available and their use. Prevention and promotion programmes for CAMH existed at a national level in over half of countries. No large changes in the number of countries reporting the existence of different types of CAMH services was observed over time.

The CAMH workforce is not sufficient to support the population's needs. The median CAMH workforce shows a dominance of psychologists, mental health nurses and psychiatrists with less social workers and occupational therapists. For each psychiatrist, there are 76 000 children and adolescents (inclusive of those with and without mental health conditions). The number of child and adolescent psychiatrists has fluctuated

over time. Large variations are seen across countries. More data is needed, including on competencies, training and support.

The service received by children and adolescents with mental health conditions varies greatly across the Region. Approximately two thirds of countries reported to have a mechanism in place to assess the quality of CAMH services and half reported to have guidance in place to facilitate transition from child to adult mental health services. Exemption fees for adolescents to access CAMH services were not provided by one fifth of countries. Limited data showed large variations in treatment rates.

Action is needed. Mental health needs are increasing for CAY across the Region, and there are large variations and gaps in the response. Existing recommendations are confirmed, including to strengthen CAMH services across the continuum of care, enhance data collection and advocate for investment. There is need for intersectoral action and mainstreaming of CAY mental health in all policies (see the Paris Outcome Statement[1] developed by WHO Regional Office for Europe).

There is also a need to standardize and improve the QoC so that CAY can access high-quality mental health care regardless of where they access it. Nine possible actions are presented to improve the quality of CAYMH care.

1. Develop and coordinate national action plans, policies and legislation to improve the quality of CAYMH care.
2. Incorporate incentives, including financing tools to complement quality improvement and innovation for CAYMH.
3. Set quality standards, protocols and clinical guidelines for CAYMH care.
4. Embed continuous quality improvement across systems and support for CAYMH.
5. Re-design service models and delivery around the needs and preferences of children, young people and their caregivers.
6. Deeply engage and empower children, young people, their families and communities.
7. Invest in a CAYMH workforce that can meet the demands and needs of the population.
8. Measure mental health outcomes that matter to children, young people and families.
9. Research and share lessons on what works to improve the quality of CAYMH care.

[1] See Outcome statement of the regional high-level conference on mental health in all policies: address challenges and design shared solutions: 16-17 June 2025 Paris, France. Copenhagen: WHO Regional Office for Europe; 2025 (https://iris.who.int/handle/10665/381671).

Chapter 1

Introduction

Background

There is a strong rationale for addressing the mental health needs of children and young people (CAY). Half of people with mental health conditions experience their first onset by ages 19–20 with peak age of onset at age 15 *(1)*. Mental health conditions have ongoing challenges for social, health and economic outcomes for the individual and their communities throughout their lives *(2)*.

Childhood is a critical period for determining mental health and well-being over the life course *(3)* and provides a unique opportunity to intervene to improve mental health outcomes across the life course *(4, 5, 6)*. Today's CAY in the WHO European Region are exposed to multiple stressors, including conflict, emergencies, struggling economies, unregulated digital environments, the effects of climate change and after-effects of the coronavirus pandemic *(7, 8)*.

Child and youth mental health (CAYMH) is an increasing area of interest in the Region, with it being cited as the second highest priority for child and adolescent health more generally by WHO Member States *(9)*. An increase in CAY seeking mental health support has been observed across the Region *(10)*, and CAYMH is one of the core priorities of the Pan-European Mental Health Coalition *(11)*.

Despite this compelling need and interest, most CAY requiring mental health support do not receive the care they need. When CAY do access care, it is of variable quality and access to evidence-based effective interventions may not be available *(2, 3, 8)*. It is clear that action is needed to improve mental health outcomes for CAY across the Region. This report aims to collate data relevant to CAYMH across the Region to paint a picture of the current status of CAYMH and make evidence-informed recommendations to improve quality of care (QoC).

Need for this report

Little is known about the status of CAYMH across the Region, including current statistics and trends and the response from governments to meet the mental health needs of CAY. Numerous surveys and datasets, which include aspects relevant to CAYMH across the Region, exist; however, until now, this data has remained dispersed.

Aims of this report

This report aims to collate data relevant to CAYMH at a regional level to develop an understanding of the current status of CAYMH. It aims to present data on the current situation of CAYMH (prevalence rates, environmental risk and protective factors) and the response (governance, services, multisectoral support, workforce and implementation of services).

Overall, it is hoped that this report will inspire change, promote action and evoke enthusiasm to take forward and improve the quality of CAYMH in all of countries within the Region.

Chapter 2

Methods

Eligibility criteria

To find datasets relevant to CAYMH that provided information specifically about the Region, the following inclusion and exclusion criteria were applied (Table 1).

Table 1: Inclusion/exclusion criteria

Inclusion	Exclusion
• Dataset from any international body including elements of CAYMH, which aim to cover all 53 countries in the Region • Dataset from WHO including elements of CAYMH, which aim to cover all or a subsection of 53 countries in the Region • Datasets published from 2018 onwards – when these datasets included trend data, data from 2000 was used to observe trends over time	• Datasets not including elements related to CAYMH • Dataset from WHO including elements of CAYMH, which aims to cover one or two countries • Dataset from international bodies including elements of CAYMH, which do not aim to cover all (or almost all) 53 countries in the Region • Datasets from national or country-specific bodies or institutions • Datasets published before 2018

Search strategy

A pragmatic approach was used to find datasets and reports that met the inclusion/exclusion criteria through online searches (i.e. WHO publications database, search engines) and consultation with WHO staff. When a report was found, WHO staff in charge of the dataset were communicated with in order to gain access to the original dataset. Data validation by countries was conducted by WHO at the time of the publication of individual datasets, but no separate data validation was done for the purposes of this report.

Chapter 3

Results

The following were found for inclusion in the report:

- 16 WHO reports *(12–27)*, which outlined data relevant to CAYMH at the Region level (12 from the Region *(9, 12, 16–24, 26)* and four global *(13–15, 27)*); and
- three databases, including the WHO Global Health Estimates *(28)*, WHO Mental Health Atlas (unpublished)[2] and Global Burden of Disease Studies *(29)*.

The results were divided into eight themes as follows and are discussed in more detail throughout the report:

1. CAYMH and substance use conditions
2. Suicide in children and youth
3. Child and adolescent mental health (CAMH) and well-being
4. Environmental factors impacting CAYMH
5. Governance
6. Availability of mental health services for children and adolescents
7. Mental health workforce for children and adolescents
8. Implementation of mental health services for children and adolescents.

[2] World Health Organization, unpublished data from Mental health atlas for the WHO European Region retrieved through personal communication, 15 October 2025.

1. CAYMH and substance use conditions

Epidemiological data and estimates on CAYMH and neurodevelopmental and substance use conditions provides information about population trends and demand for CAYMH services across the Region.

Mental health conditions affect one in seven children and adolescents aged 0–19 years old

Over 30 million (30 470 985) – approximately one in seven (one in 7.2; 13.86%) – children and adolescents aged 0–19 years old across the Region are living with a mental health condition *(29)*.

Anxiety disorders account for half of mental diagnoses in children and adolescents aged 0–19 years old

Anxiety disorders are the most common mental health condition in children and adolescents aged 0–19 years old (affecting over fifteen million), followed by depressive disorders (affecting over 4.4 million) *(29)* and attention deficit/hyperactivity disorders (affecting 3.7 million) (Table 2).

Table 2. Point prevalence (cases at any given point in the year) and prevalence percentage of mental disorders in children and adolescents aged 0–19 years across the Region

Type of mental health condition	Number and percentage of children and adolescents aged 0–19 years old with condition
Total number living with mental disorders	30 470 985 (13.86%)
Anxiety disorders	15 706 460 (7.15%)
Attention deficit/hyperactivity disorders	3 691 541 (1.68%)
Autism spectrum disorders	2 084 793 (0.95%)
Bipolar disorder	399 513 (0.18%)
Conduct	3 653 675 (1.66%)
Depressive disorders	4 411 923 (2.01%)
Eating disorders	631 049 (0.29%)
Idiopathic developmental intellectual disability	1 833 148 (0.83%)
Other mental disorders	305 869 (0.14%)
Schizophrenia	44 709 (0.02%)

Source: (29).

Substance use conditions affect less than one in 100 children and adolescents aged 0–19 years old

Over 1.7 million children and adolescents (0.79% of the population) aged 0–19 years are living with a substance use condition across the Region (Table 3) *(29)*.

Table 3 Point prevalence (cases at any given point in the year) of substance use in children and adolescents aged 0–19 years across the Region

Type of condition	Number and percentage of children and adolescents aged 0–19 years old with condition
Overall living with a substance use condition	1 740 666 (0.79%)
Alcohol use condition	619 172 (0.28%)
Drug use condition	1 134 849 (0.52%)

Source: (29).

CAYMH and substance use conditions are a leading cause of disease burden

Mental and substance use conditions were the leading cause of disability-adjusted life years (DALYs). One DALY represents the loss of one year of full health for males, females and overall for both the age group 15–29 years old and 0–29 years old *(28)*. For those aged 0–14 years, mental and substance use disorders were the third leading cause of DALYs *(28)* (Table 4).

Table 4. Top three causes of DALYs for CAY across age groups across the Region

	Ranking cause of DALYs, both males and females (number of DALYs)		
Age group (by years)	1st	2nd	3rd
0–29	Mental and substance use conditions (7 522 364)	Neonatal conditions (3 918 367)	Unintentional injuries (3 564 967)
0–14	Neonatal conditions (3 546 761)	Congenital anomalies (2 352 785)	Mental and substance use conditions (1 677 425)
15–29	Mental and substance use conditions (5 844 938)	Unintentional injuries (2 506 564)	Musculoskeletal diseases (2 103 979)

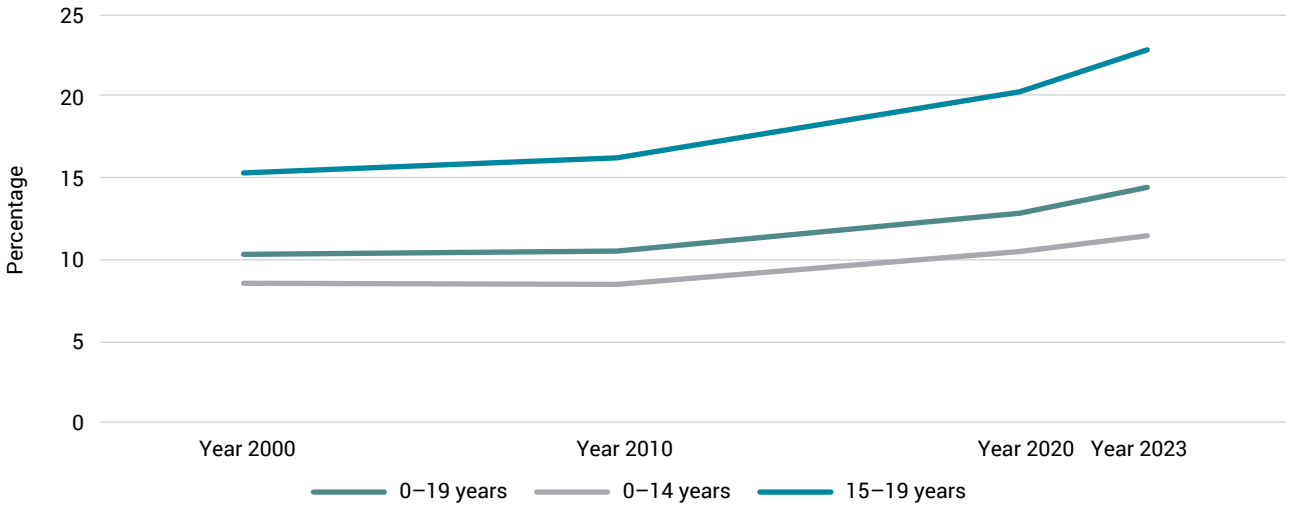
Source: (28).

The prevalence of children and adolescents living with mental health conditions has increased over time

Between 2000 and 2010, the percentage of children and adolescents living with mental health conditions remained similar; however, an increase was seen between 2010 and 2023 across all age groups *(29)*.

Between 2010 and 2023, an increase of 35.56% was seen in the rate of mental health conditions for those aged 0–19 years old. The increase in the rate of mental health conditions between 2010 and 2023 was steeper for those aged 15–19 years old (an increase of 41.55%) than for those aged 0–14 years old (an increase of 35.38%) (Fig. 1 and Table 5) *(29)*.

Fig. 1. Percentage of children and adolescents living with mental disorders between 2000 and 2023 across all age groups.



Source: (29).

Table 5. Point prevalence (%) of mental health conditions in children and adolescents aged 0–19 years, 0–14 years and 15–19 years across time across the Region

Year of prevalence living with a mental health condition	0–19 years (%)	0–14 years (%)	15–19 years (%)
2000	10.12	8.31	14.85
2010	10.35	8.22	16.15
2020	12.53	10.19	19.88
2023	13.86	11.02	22.36

Source: (29).

The prevalence of children and adolescents living with anxiety has doubled since the year 2000

Overall, between 2000 and 2023, the percentage of children and adolescents aged 0–19 years old living with anxiety doubled (from 3.51% to 7.15%; an increase of 103.70%). The increase was steepest between 2010 and 2023 (from 3.83% to 7.15%; an increase of 86.66%) *(29)*.

The increase in the rate of anxiety conditions between 2000 and 2023 was steeper for those aged 15–19 years old (an increase of 130.97%) than for those aged 0–14 years old (an increase of 92.7%%) (See Table 6) *(29)*.

Table 6. Point prevalence (%) of anxiety conditions in children and adolescents aged 0–19 years, 0–14 years and 15–19 years across time across the Region

Year of prevalence living with anxiety	0–19 years (%)	0–14 years (%)	15–19 years (%)
2000	3.51	2.86	5.19
2010	3.83	2.91	6.31
2020	5.72	4.61	9.23
2023	7.15	5.52	12.00

Source: (29)

The prevalence of children and adolescents living with substance use conditions has remained relatively stable over time

Between 2000 and 2023, the prevalence of children and adolescents living with substance use conditions has remained roughly the same across all age groups (Table 7) *(29)*.

Table 7. Point prevalence (%) of substance use in children and adolescents aged 0–19 years, 0–14 years and 15–19 years across time across the Region

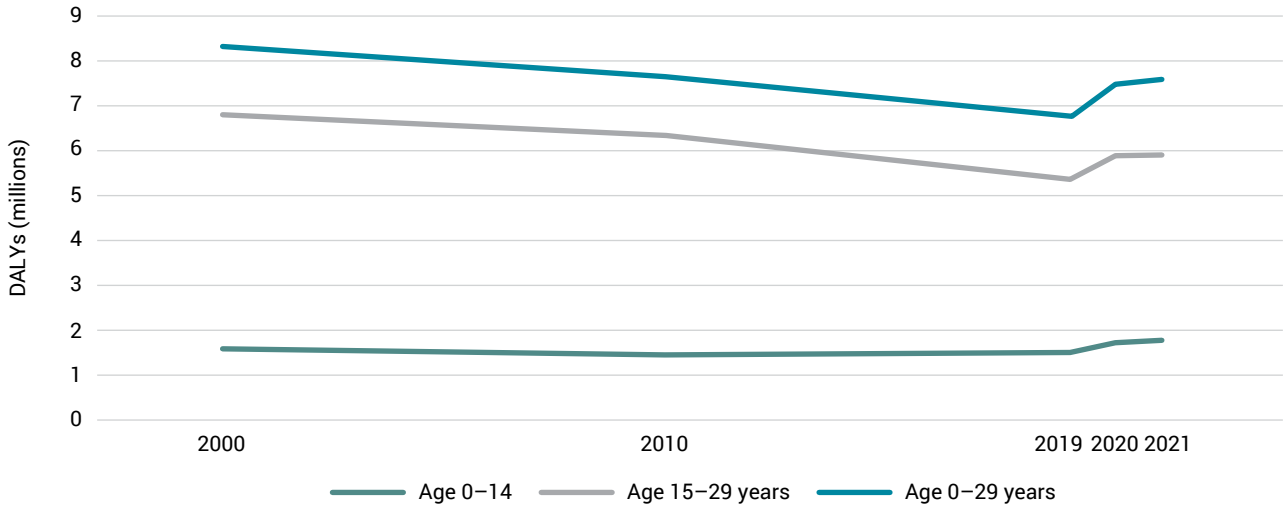
Year of prevalence living with substance use disorder	0–19 years (%)	0–14 years (%)	15–19 years (%)
2000	1.07	0.12	3.55
2010	0.98	0.10	3.36
2020	0.81	0.10	3.04
2023	0.79	0.09	2.88

Source: (29)

The burden of CAYMH and substance use conditions has fluctuated over time

BBetween 2000 and 2019 there was an improvement in burden across all age groups between, however the burden increased between 2019 and 2021 across all age groups (Fig. 2).

Fig. 2. DALYs for mental health conditions for CAY across the Region over time



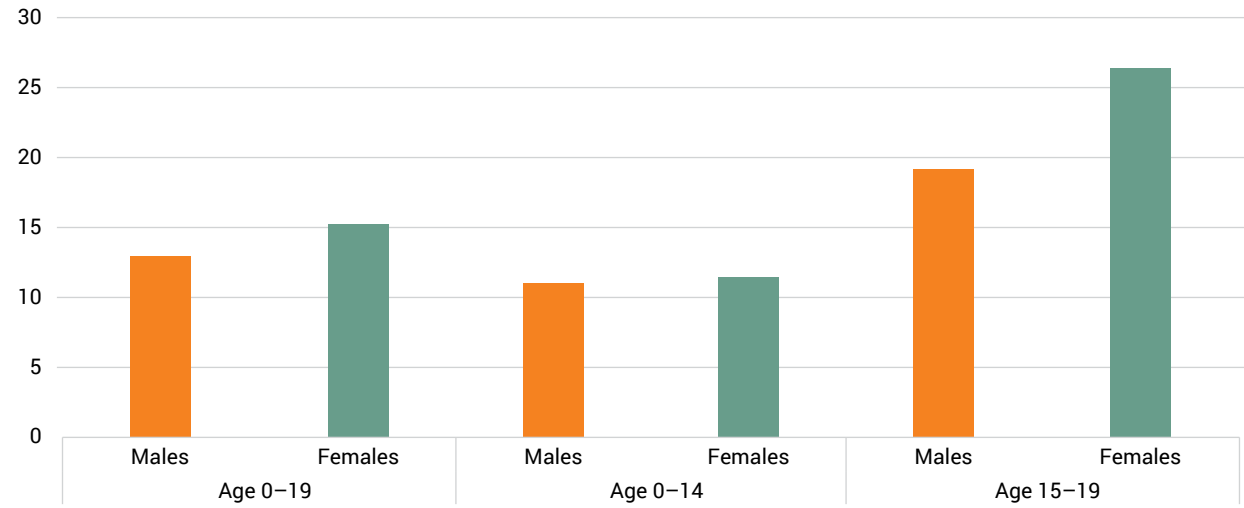
Source: (28).

Females are more likely to be living with a mental health condition than males, with older females faring worse

Overall, in the age group 0–19 years old, there are more females living with a mental health condition than males (14.79% of females compared with 12.99% of males) *(29)*.

Females fare worse than males across all age groups, with the divide widening as age increases. At age 15–19 years, one in four females are living with a mental health condition (25.86%) compared with one in five males (19.06%). At 0–14 years, the divide is less with 11.09% of females living with a mental health conditions compared with 10.95% of males (See Figure 3) *(29)*.

Fig. 3. Percentage of males and females aged 0–19 years, 0–14 years and 15–19 years living with mental health conditions across the Region

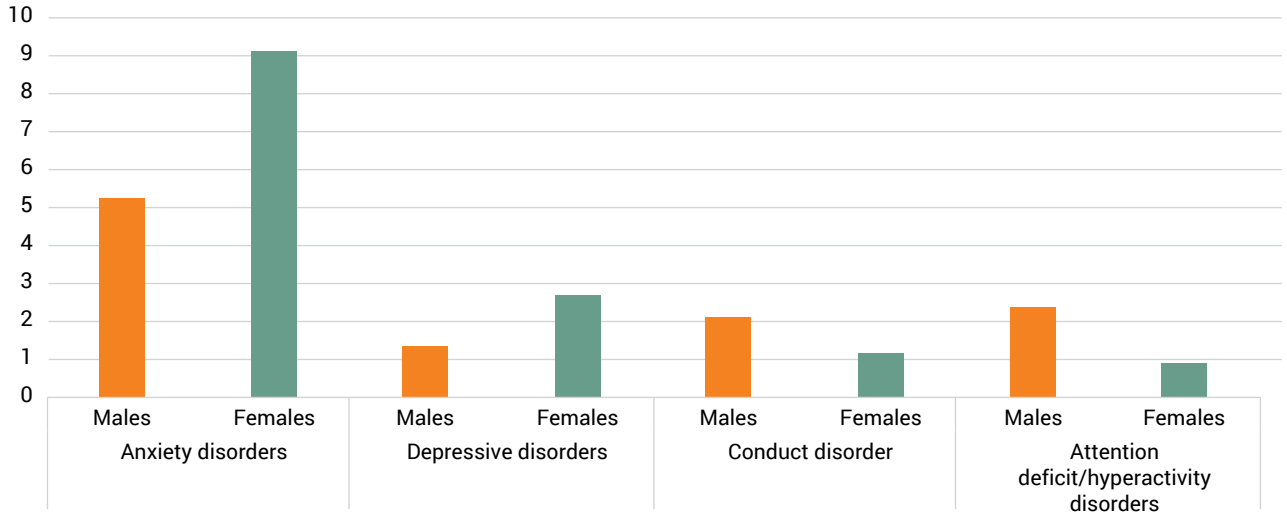


Source: (29).

There are gender differences across diagnoses

Gender differences are observed within diagnoses. For example, the rate of females living with anxiety is almost double that of males (9.14% of females compared with 5.27% of males), and the rate of males living with attention deficit/hyperactivity is over double that of females (2.39% of males compared with 0.92% of females) *(29)*. See Fig. 4 for more information.

Fig. 4. Percentage of males and females aged 0–19 years living with the four most common mental health conditions across the Region

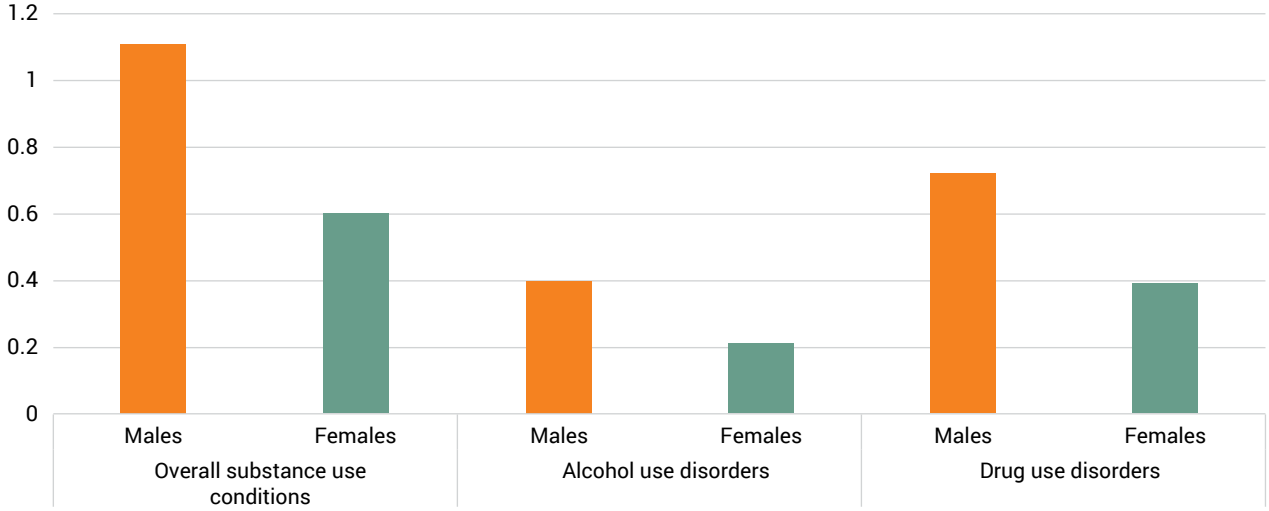


Source: (29).

Substance use conditions are more prevalent in males

In the age group 0–19 years old, more males are living with a substance use condition than females (1.00% of males compared with 0.55% of females) *(29)* as can be seen in Fig. 5 below.

Fig. 5. Percentage of children and adolescents aged 0–19 years living with substance use disorders disaggregated by gender



Source: (29).

The burden of mental health and substance use conditions is approximately the same for males and females

The burden of mental health and substance use conditions was approximately the same for males and females at age 0–29 years (52% male; 48% females), 0–14 years old (50% male; 50% female) and 15–29 years old (48% male; 52% female) *(28)*.

Mental health and substance use conditions are more prevalent in older children and adolescents

The prevalence of mental health and substance conditions increased with age, with one in 10 (11.02%) 0–14 year-olds living with a mental health condition compared with more than one in five (22.36%) of those aged 15–19 years old; and 0.09% children and adolescents aged 0–14 years old living with a substance use condition compared to 2.88% of those aged 15–19 years old (Table 8 and Table 9) *(29)*.

Table 8. Percentage of children and adolescents living with mental health conditions by age groups

	Estimated number of people within age group living with the condition across WHO European Region in 2023 (%)	
	0–14 years	15–19 years
Total number living with mental disorders	18 146 619 (11.02%)	12 324 366 (22.36%)
Anxiety disorders	9 093 466 (5.52%)	6 612 995 (12.00%)
Attention deficit/ hyperactivity disorders	2 598 444 (1.58%)	1 093 097 (1.98%)
Autism spectrum disorders	1 593 034 (0.97%)	491 759 (0.89%)
Bipolar disorder	70 105 (0.04%)	329 408 (0.60%)
Conduct disorders	2 627 346 (1.60%)	1 026 328 (1.86%)
Depressive disorders	1 620 531 (0.98%)	2 791 392 (5.06%)
Eating disorders	196 871 (0.12%)	434 177 (0.79%)
Idiopathic developmental intellectual disability	1 375 436 (0.84%)	457 712 (0.83%)
Schizophrenia	5 594 (0.00%)	39 114 (0.07%)
Other mental disorders	40 788 (0.02%)	265 081 (0.48%)

Source: (29).

Table 9. Percentage of children and adolescents living with substance use conditions by age groups

	Estimated number of people within age group living with the condition across WHO European Region in 2021 (%)	
	0–14 years	15–19 years
Total living with a substance use condition	151 849 (0.09%)	1 588 816 (2.88%)
Alcohol use condition	68 130 (0.04%)	551 042 (1.00%)
Drug use condition	83 814 (0.05%)	1 051 035 (1.91%)

Source: (29).

2. Suicide in children and youth

While the links between suicide and mental health conditions are well established, particularly for depression and alcohol use, some may happen impulsively in moments of crisis. Suicide rates are used as an indicator to measure progress in global mental health. Understanding patterns and trends in suicide can provide valuable information from which to plan services.

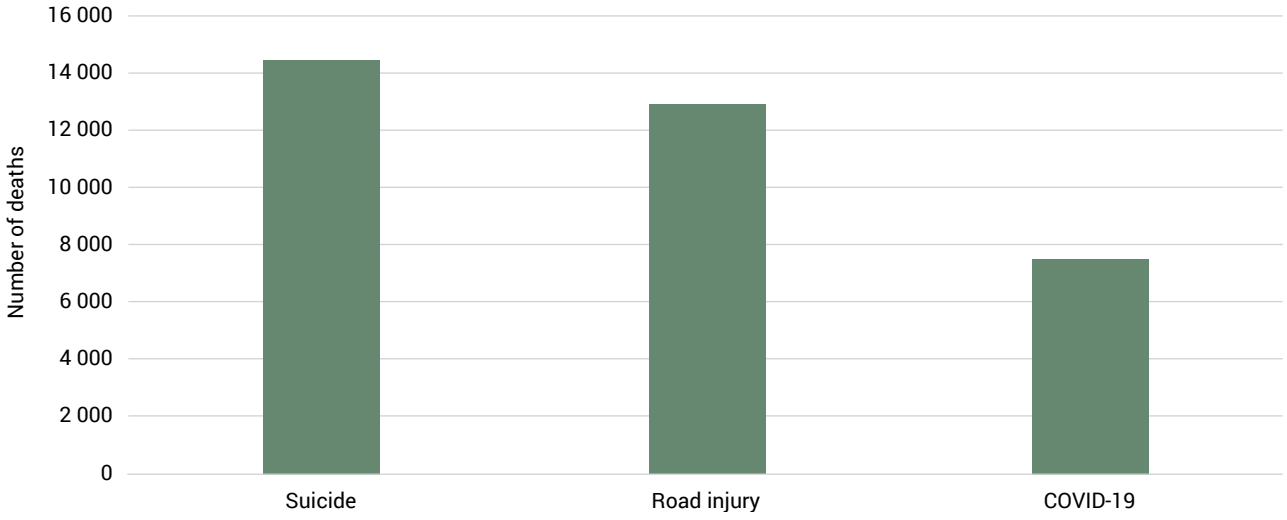
Suicide is the third leading cause of death for CAY aged 0–29 years old

Suicide is the third leading cause of death for those aged 0–29 years old overall (n=15 056) *(28)*.

Suicide is the leading cause of death for young people aged 15–29 years old

Suicide is the leading cause of death for young people aged 15–29 years old (n=14 467, Fig. 6), the third leading cause of death for those aged 0-29 years old (n=15 056) and the 11th leading cause of death for those aged 0-14 years old (n=589).

Fig. 6. Top three leading causes of death for persons aged 15–29 years old in the Region



COVID-19: coronavirus disease

Source: (28).

Males are more likely to die by suicide than females

Males were three times (3.35) more likely to die by suicide than females overall (age group 0–29 years old) and at ages 15–29 years old *(28)* (Table 10).

Death by suicide was the highest cause of death for males and females separately aged 15–29 years *(28)*, highlighting the importance of this issue across both males and females.

Table 10. Suicide rates for CAY across age groups and disaggregated by gender in the Region in 2021

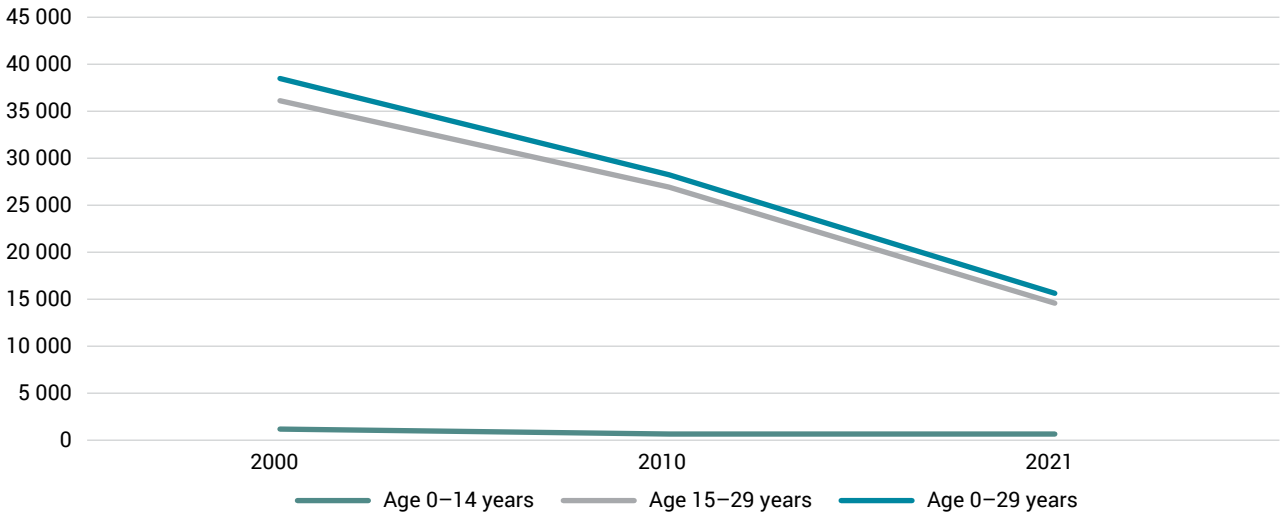
Age range (years)	Number of deaths by suicide (male)	Number of deaths by suicide (female)	Total number of deaths by suicide	Gender proportion	Proportion female to male
0–29	11 498	3 558	15 645	77% male; 23% females	1:3.2
0–14	356	233	589	60% males; 40% females	1:1.53
15–29	11 142	3 325	14 467	77% male; 23% females	1:3.35

Source: (28).

The number of CAY dying by suicide has decreased over time

Since the year 2000, suicide numbers have dropped by 60% for those aged 15–29 years old; for those aged 0–14 years old, they halved (49%) *(28)* (Fig. 7).

Fig. 7. Deaths by suicide in CAY across age groups in 2000, 2010 and 2021



Source: (28).

3. CAMH and well-being

Data on CAMH and well-being provides additional information on population trends and needs for mental health across the continuum of care. The *Health Behaviour in School-aged Children* studies (44 countries in central Asia Europe, and Canada survey, in 11-, 13- and 15-year-olds) are the largest adolescent health surveys globally and contain questions on mental health and well-being *(19)* as well as related factors of social media use, gaming and substance use.

Most adolescents report positive well-being; however, symptoms of distress were reported by one in three

The average mental well-being score was 61.1 out of 100 on the *WHO-5 Well-being index (30)*, where scores of 50 or less indicate "poor well-being" *(30)*, and the average life satisfaction score was 7.5 out of 10 (with higher scores indicating greater satisfaction).

One third of respondents reported nervousness (33%), irritability (33%) and difficulties getting to sleep (29%); and one in four (25%) reported feeling low. Sixteen percent reported feeling lonely "most of the time" or "always" in the past year *(19)*.

Females, older adolescents and adolescents from low socioeconomic backgrounds reported worse mental health and well-being outcomes

Males reported better outcomes on all well-being measures (i.e. life satisfaction, mental well-being, loneliness and multiple health complaints) than girls *(19)*. Those from more affluent families scored better than those from low affluence on the mental well-being measures *(19)*. Older adolescents reported worse outcomes on well-being measures, with the differences being more pronounced for females than males *(19)*.

Adolescent mental health and well-being has decreased over time

Average life satisfaction declined slightly from 2018 to 2022 (from 7.74 to 7.47), and the prevalence of multiple health complaints increased from 3% in 2014 to 36% in 2018 and 44% in 2022 *(19)*.

The number of adolescents who reported problematic use of social media and reported to be at risk of problematic gaming has increased over time

Between 2018 and 2022, increases were seen in the prevalence of reported problematic social media use (7% in 2018 versus 11% or one in ten in 2022), non-problematic gaming (61% in 2018 versus 68% in 2022) and a risk of problematic gaming (10% in 2018 versus 12% in 2022) *(23)*.

Females are more at risk of problematic social media use and males are more at risk of problematic gaming

Females reported higher levels of continuous online contact and problematic social media use than males *(23)*. More males were at risk of problematic gaming than females *(23)*, with this being most frequently reported by 11-year-olds (14%) *(23)*. Problematic social media use was most recorded among 13-year-olds *(23)*.

Alcohol is the most used substance, followed by e-cigarettes or "vaping"

More adolescents reported having used alcohol (35%) at least once when compared to e-cigarettes (18%), cigarettes (13%) and cannabis (12%) *(22)*.

Substance use increased with age, and the type of substance use varied depending on socioeconomic status

More males than females reported substance use at age 11, and this gender gap narrowed or disappeared from age 13 *(22)*. Use of substances increased sharply with age *(22)*. Adolescents from low-affluence families showed a higher prevalence of cigarette smoking, while e-cigarettes and alcohol use were more prevalent among high-affluence adolescents *(22)*.

There have been mixed trends in the use of substances over time

From 2018 to 2022, an overall increase in alcohol use was observed among older females, as was a decrease in alcohol use among 15-year-old males *(22)*. Smoking decreased between 2018 and 2022 for 15-year-old males *(22)*.

4. Environmental factors impacting on CAYMH and well-being

An unsafe or challenging environment puts children and adolescents at risk for experiencing distress and mental health conditions, whereas a safe and supportive environment can prevent the onset of mental health conditions and promote good mental health *(4)*.

Adverse childhood experiences (ACEs) are common

ACEs include exposure to violence in childhood (e.g. experiencing or witnessing physical, sexual or psychological violence) and are risk factors for mental health conditions *(17, 31)*. ACEs are experienced by approximately half (42–51.5%) of CAY *(16)*. Child homicide rates in the Region are relatively low compared to other regions, at 0.7 in males and 0.5 in females per 100 000 *(15)*.

School environments are experienced as negative by many

Adolescents spend a significant proportion of their daily lives in school environments. Having a supportive and safe school environment allows young people to thrive *(4)*.

High school satisfaction was reported by only one in four (25%) *(25)* and high school pressure was reported by just under half of adolescents (43%) *(24)*. One in 10 adolescents reported being bullied *(21)* and one in ten were involved in physical fights *(21)*. Support from classmates was reported as high by just over half (55%) of adolescents *(24)*.

Older adolescents and females were more likely to report a negative experience of school *(24)*. Males were more likely to report bullying others and being involved in fights *(21)*. The number of adolescents reporting a negative experience of school increased over time, with females being more impacted (2018 versus 2020–2021) *(24)*. Rates of adolescents who reported bullying others at school have remained relatively stable since 2018 *(21)*.

Cyberbullying in online environments was experienced by one in seven adolescents

Cyberbullying was experienced by 15% of adolescents *(21)*.

Social support levels were generally high, but one in five reported no social support

High levels of social support are a protective factor for CAMH, and low levels of social support can be a risk factor for mental health conditions. Social support was generally perceived as high by adolescents: two thirds (68%) reported high levels of family support *(24)* and over half (58%) reported high levels of peer support *(24)*. However, a significant proportion (21%) of adolescents did not perceive high support from either their families or peers *(24)*.

Females reported higher levels of peer support, and males reported higher levels of family support *(24)*. With an increase in age, lower levels of social support were reported across all family- and peer-related variables for both genders, with the steepest decline taking place between ages 11 and 13 years old *(24)*. Higher family

affluence was associated with higher levels of family and peer support and improved communication with parents *(24)*. Levels of family and peer support decreased from 2018 to 2021–2022, with girls aged 13 and 15 being particularly affected *(24)*.

The COVID-19 pandemic impacted adolescent mental health and well-being in mixed ways

Approximately equal proportions of adolescents reported a negative (30%), neutral (38%) and positive (30%) impact from the COVID-19 pandemic on their mental health and well-being. Girls, older adolescents and those from lower socioeconomic backgrounds fared worse *(18)*.

The COVID-19 pandemic negatively affected the mental health and well-being of 42% of children aged 6–9 years old, as reported by caregivers

Approximately half (46%) of the caregivers of children aged 6–9 years old reported that their child's capacity to have fun had worsened, 22.8% reported that their child's capacity to pay attention had worsened and 20% reported that their child was feeling sad more often as a result of the COVID-19 pandemic *(17)*.

5. Governance

To improve mental health outcomes for CAY, commitment is required from all levels of health systems, starting with governance and leadership. Policies, plans and laws across multiple sectors should protect and promote CAMH, ensure access to high-quality CAMH care, and protect human rights *(5)*.

One in five countries in the Region reported to lack a policy or plan for CAMH

Of responding countries, most reported having a mental health policy or plan specifically for children (n=22/28, 79%) or adolescents (n=21/28; 75%), and one in five stated they do not have a mental health policy or plan specifically for this population (21%; n=6/28 lacking a policy/plan for children, and 25%; n=7/28 lacking a policy/plan for adolescents). There was no response from 25 countries (47% of the 53 Member States) *(32)*.

Of those which reported the year of publication of the mental health policy or plan for children or adolescents, most stated that it had been published or updated since 2020 (n=19/22; 86% for children policies/plans, and n=21/30; 70% for adolescent policies/plans) *(32)*.

The majority of Member States in the European Union, Norway and Iceland reported partially or fully implementing a mental health policy for children and adolescents (aged up to 19 years; n=23/29; 79%) and/or young people (aged 15–24 years; n=21/29; 72%) *(26)*.

Increase in the number of countries with a policy or plan for CAMH over time

Out of 42 countries for which data is available from both 2016 and 2020, three of these countries developed a new CAMH strategy during this time period *(13, 27);* and of the 27 countries for which data is available from both 2020 and 2024, five of these countries reported to develop a new CAMH strategy (answer changed from "no" to "yes") *(27, 32)*.

Limited data on multisectoral policies and plans for CAMH

With regards to educational settings, three quarters of responding countries (80%; n=30/40) from the Region reported to have a national school policy that includes adolescent mental health in 2016–2017 *(12)*; and three quarters of responding countries (80%; n=30/40) reported having a strategy for health-promoting schools in 2021, which includes a focus on mental health *(25)*. Over two thirds (69%; n=20/29) of countries in the European Union, Iceland and Norway reported having a policy on mental health in educational settings that had either been partially or fully implemented *(26)*.

To prevent violence, less than one third (28%) of 44 countries had at least one indicator related to violence against children in national action plans, 64% reported support of "safe environments strategy"[3] in place for children and youth, and 78% stated they have national mechanisms in place to support the "parent and caregiver strategy", which includes parenting groups to nurture non-violent parenting *(15)*.

[3] The safe environments strategy is one of the seven WHO "INSPIRE" strategies for ending violence against children aims to create and sustain safe physical and social environments where children and youth gather and spend time. Physical and emotional safety in public spaces allows people to move freely, access community resources, and fully participate in learning, working, playing and citizenship *(15)*.

No data available on mental health legislation for children and adolescents

79% (n=23/29) of responding countries in the Region reported the existence of a stand-alone law for mental health. However, no information was available on how this applied to children and adolescents, or how their rights are protected *(27)*.

A lack of data on multisectoral legislation to support CAMH and well-being

Information on laws to prevent violence against children suggested that the majority (78%) of Member States in the Region reported a high level of laws to limit youth access to firearms to prevent violence against children *(15)*.

6. Availability of mental health services for children and adolescents

A network of interconnected services for CAYMH is recommended, consisting of those integrated into general health care, community mental health services and non-health settings (e.g. schools, youth centres, digital settings) *(33)*. Understanding what mental health services exist allows for informed recommendations.

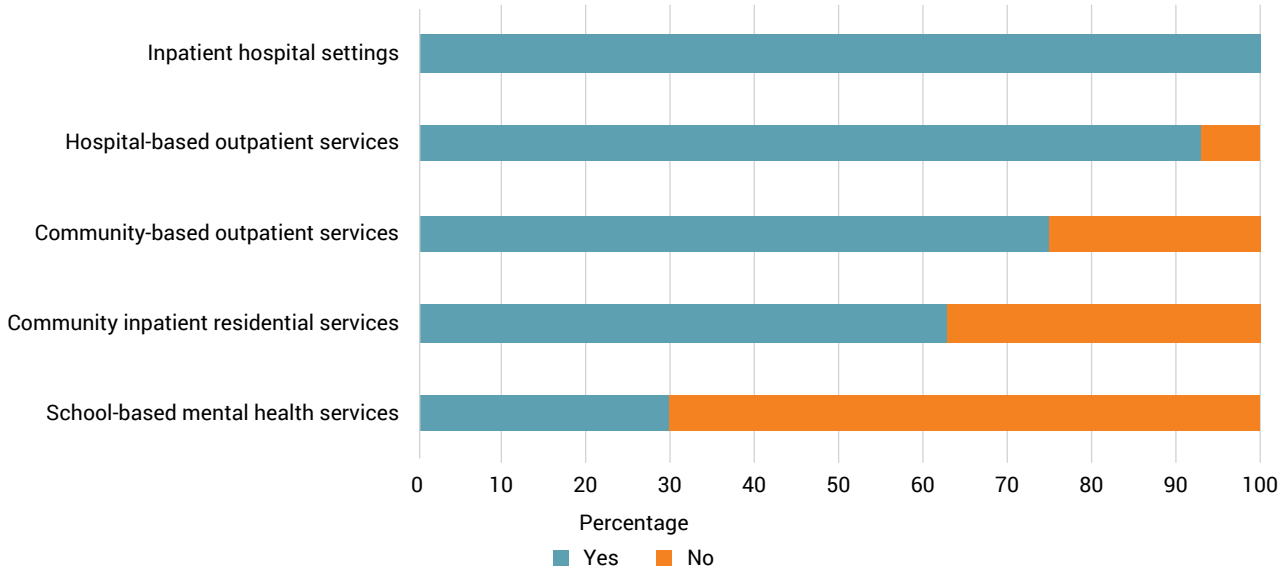
More countries report the existence of CAMH services in hospital than in community-based settings

CAMH services were most commonly reported to exist across different levels of the health system.

- Most commonly, services were reported in inpatient hospital settings (mental health hospital or general hospital); (100% of responding countries (n=29/29) *(32)*).
- The next most reported CAMH services were in hospital-based outpatient services (93% of responding countries; n=25/29 *(32)*).
- Community-based outpatient services were the next most reported CAMH services (75%; n=18/24 *(32)*).
- Community inpatient residential services (e.g. group housing for young people with psychosis or developmental disabilities) were the second least reported type of CAMH services (reported by 63% of responding countries; n=15/24 *(32)*).
- School-based mental health services were the least reported type of CAMH services (reported by 30% of responding countries; n= (16)/25 *(32)*).

See Fig. 8 for more information. Community mental health services providing early intervention and follow-up support for children and adolescents experiencing a first episode of severe mental illness were reported to be available in 33 (75%; n=33/44) of responding countries surveyed in 2019–2020 *(25)*.

Fig. 8. Percentage of countries reporting to have CAMH services broken down by type across the Region



Source: (25, 27).

Limited data show more visits to community-based outpatient services than hospital-based outpatient services

A limited number of countries provided information on the number of CAMH community outpatient visits (n=8) and facilities (n=8), and hospital-based CAMH outpatient visits (n=12) and facilities (n=12) *(32)*.

The median numbers of outpatient facilities and visits per 100 000 are shown in Table 11 below *(16)*. The median number of visits and facilities for hospital-based outpatient services was approximately half that for community-based services. Large ranges were observed for the number of facilities (range of 3.96 and 3.00 per 100 000) and visits per 100 000 population (ranges of 11 204 and 3249 per 100 000) *(32)*.

Table 11. Median availability and number of outpatient mental health facilities and visits for children and adolescents per 100 000 population across the Region

Type of outpatient mental health services specifically for children and adolescents	Median number of facilities per 100 000	Median number of visits per 100 000
Hospital-based outpatient services (e.g. for developmental disabilities)	0.13 (n=12; range: 0.05–4.01)	382.99 (n=12; range 0.12–11 204)
Community-based outpatient services (e.g. home visits, community-based mental health outpatient)	0.37 (n=8; range 0.05–3.50)	668.04 (n=8); range 1.02–3 250)

Source: (32).

Only one country provided information on the number of visits to school based CAMH services. Hence more data is required to understand the implementation of school-based services *(32)*.

Limited data show large variation in use and availability of inpatient mental health care

The number of inpatient facilities, beds and admissions per 100 000 population was reported for CAMH hospitals or wards and inpatient community residential facilities. Data was particularly lacking for the latter, with no countries providing a number of inpatient community residential facility admissions. As shown below in Table 12, the range for each of these was very high, highlighting the large variability in the use and availability of inpatient mental health care for children and adolescents across the Region *(32)*. Data was unavailable for CAY admitted to adult inpatient services.

Table 12. Mental health inpatient service type, median number of facilities, beds and admissions per 100 000 population for reporting countries in the Region

Type of inpatient services specifically for children and adolescents	Median number of facilities per 100 000	Median number of beds per 100 000	Median number of admissions per 100 000
Mental health hospital or wards in general hospital	0.11 (n=19; range 0.03–1.24)	1.97 (n=20; range 0.34–5.46)	36.76 (n=22; range 0.99–118.49)
Inpatient community residential facilities	0.10 (n=4; range: 0.05–0.70)	1.68 (n=4); range 0.11–7.35)	not applicable; no data.

Source: (32).

No significant changes in the number of countries reporting the existence of inpatient or outpatient CAMH services over time

From the 46 countries in which data is available across both 2016 *(13)* and 2020 *(27)*, one country reported acquiring inpatient CAMH services (changing a response from "no" in 2016 to "yes" in 2020) and two reported losing inpatient CAMH services (changing a response from "yes" in 2016 to "no" in 2020). Of the 24 countries for which data is available across 2020 and 2024, one country reported acquiring inpatient CAMH services and none reported losing inpatient CAMH services *(27, 32)*.

From a comparison of the 37 countries for which data were available across both 2016 and 2020, one country reported developing outpatient services for children and adolescents (changing a response from "no" in 2016 to "yes" in 2020) *(13, 27)*.

From the 22 countries for which data were available across 2020 and 2024, one country reported developing hospital-based outpatient CAMH services and two countries reported losing hospital-based outpatient CAMH services; and two countries reported developing community-based CAMH services and two countries reported losing community based CAMH services *(27, 32)*.

Fluctuation in the existence of early intervention services for CAYMH over time

Between the period 2016–2017 *(12)* and 2019–2020 *(25)*, seven countries opened up early intervention services for young people (responded "no" in 2016–2017 and "yes" in 2019–2020). Of the 29 that reported they had early intervention services in place in 2016–2017, five reported their absence in 2019–2020 *(12, 25)*.

CAMH promotion and prevention programmes exist in some countries

Countries were asked what CAMH promotion and prevention programmes were implemented at a national level. The most commonly implemented were early child development programmes (n=18/26; 69%), followed by school based programmes (n=17/26; 65%), suicide prevention programmes (n=15/26; 58%), work-related programmes (n=13/23; 57%), anti-stigma programmes (n=13/27; 48%) and parental/maternal programmes (n=11/24; 46%) *(32)*.

Three quarters of countries in the European Union, Iceland and Norway (76%; n=22/29) reported to have partially or fully implemented programmes to improve mental health awareness and literacy in schools *(26)*.

Out of 44 countries responding to assess the implementation of strategies in schools to reduce violence against children *(15)*, the most reported strategy was life and social skills training (60%) followed by training to reduce violence by school staff (47%), anti-bullying training (44%), training to avoid sexual abuse (40%) and dating violence prevention (reported to be available in 24% of countries).

7. Mental health workforce for children and adolescents

A competent and appropriate mental health workforce is a key component of high-quality care provision. Staff should be equipped to develop strong therapeutic relationships, be compassionate and provide appropriate evidence-based care for CAY, and should be supported through professional development, training and supportive supervision *(34)*.

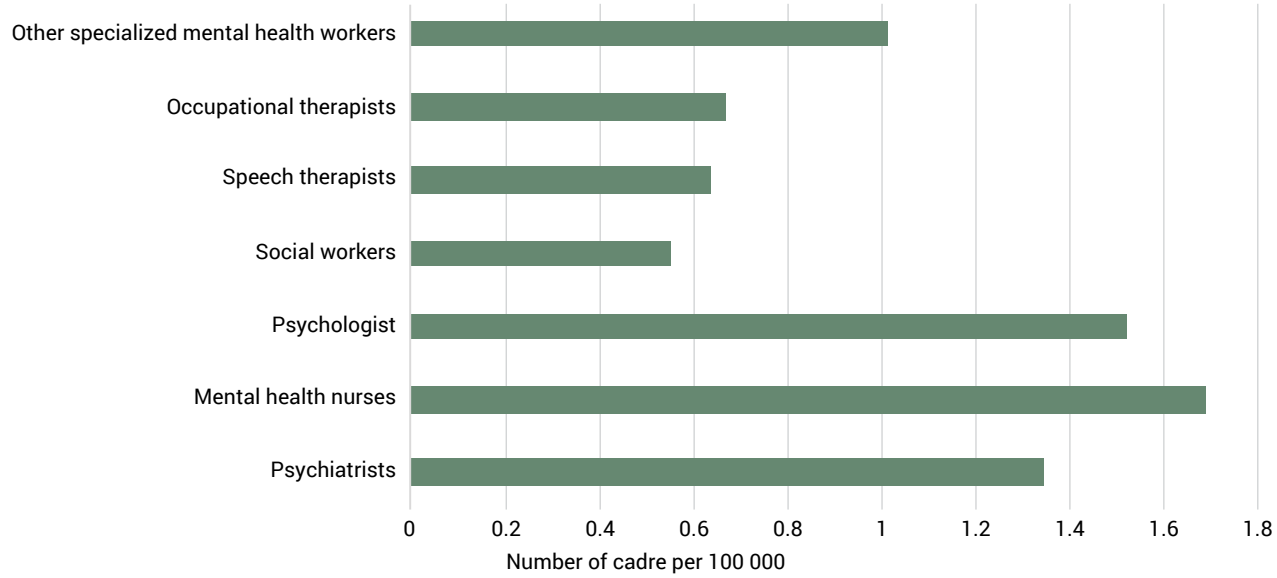
There are not enough CAMH workers to support children and adolescents with mental health conditions

The numbers of the CAMH workforce (both governmental and nongovernmental) were provided by varying numbers of countries (10 provided information on "other specialized mental health workers" and 23 provided information on "psychiatrists"). The overall median was 4.93 CAMH workers per 100 000 children and adolescents (range of 1.05–49.67) *(32)*.

The median CAMH workforce is largely composed of mental health nurses (1.66 per 100 000; n=12) followed by psychologists (1.49 per 100 000; n=13) and psychiatrists (1.32 per 100 000; n=23) *(16)*) (Fig. 9). For every one psychiatrist across the Region, there are 76 000 children and adolescents.

Out of every 100 000 children and adolescents, it is estimated that 13 860 are living with mental health conditions (13.86%), meaning there are 4.93 CAMH workers per 13 860 children and adolescents with mental health conditions, or 2811 children and adolescents with mental health conditions for every CAMH worker.

Fig. 9. Median governmental CAMH workforce per 100 000 across the Region in 2024



Source: (32).

Large variations in numbers of mental health workers across countries and cadres

The number of mental health workers (governmental and nongovernmental) varied considerably across countries among the different cadres in the mental health workforce for children and adolescent services (see Table 13) *(32)*.

Table 13. Median CAMH workforce per 100 000 by cadre across the Region in 2024

	Psychiatrists	Mental health nurses	Psychologists	Social workers	Speech therapists	Occupational therapists	Other specialized mental health workers
Range of workers per 100 000	0.26–5.31	0.37–9.24	0.26–9.03	0.09–2.02	0.07–42.08	0–1.14	0.00–12.95
Number of countries providing data	23	12	13	18	12	10	23

Source: (32).

Fluctuation in number of child and adolescent psychiatrists across time

Data for both 2016 and 2020 were available across 12 countries. Out of these, ten showed an increase in the number of child and adolescent psychiatrists, one reported a decrease and one remained roughly the same *(13, 27)*. Data were available for both 2020 and 2024 across 14 countries, all of which showed a decrease in the number of child and adolescent psychiatrists over this time *(27, 32)*. It is not clear if these fluctuations are due to methods of reporting or to psychiatrists being lost from the workforce.

8. Implementation of mental health services for children and adolescents

In addition to understanding what services are available for CAMH, it is important to understand their implementation. High-quality services are implemented with the active participation of users, uphold human rights and safety, engage with the family and community, allow for smooth transitions, provide support in a timely, appropriate and evidence-based manner and allow for data collection and quality improvement.

Two thirds of countries reported to have a mechanism in place to assess the quality of mental health services for children and adolescents

Data from 2016–2017 showed that two thirds (66%; n=29/44) of 44 responding countries reported having a mechanism in place to assess the quality of mental health services for children and adolescents; just over one third (34%; n=15/44) reported that they do not have such a mechanism *(12)*.

Existing data showed a variation of treatment rates between countries and diagnoses

Three quarters (78%; n=35/45) of 45 responding countries reported having a system in place to collect information on the number of children under 18 years treated by a mental health *(12)*.

Data on treatment rates were lacking; however, existing data indicated a large variation in treatment rates *(25)*.

- Treatment rates per 1000 children and adolescents for attention deficit hyperactivity disorder (provided by 12 countries) ranged from 0.09–20.20 *(25)*.
- Treatment rates per 1000 children and adolescents for autism spectrum disorder ranged from 0.06–85.90 *(25)*.
- Treatment rates per 1000 children for depression ranged from 0.04–8.70 *(12)*.

Over half of countries reported to have guidance to facilitate the transition from child to adult mental health services

The transition from adolescent to adult mental health services represents a critical period of vulnerability that must be managed carefully and seamlessly. Over half (58%; n=25/43) of countries reported to have guidance to facilitate the transition from child to adult mental health services, with the remaining countries reported to lack this guidance (41.86%; n=25/43) *(12)*.

Approximately half of countries reported to lack mechanisms in place for intersectoral and multistakeholder planning and monitoring of CAMH services

Approximately half (55%; n=21/38) of responding countries reported to lack mechanisms for intersectoral and multistakeholder planning and monitoring of CAMH services, with the remaining reporting to have these mechanisms *(25)*.

Exemption fees for adolescents to access mental health care were not provided by one fifth of countries

The cost of accessing services can pose significant barriers to those seeking care. Available data from 2018–2019 suggests that 82% (n=31/38) of countries in the Region reported to have a policy in place that ensures adolescents are exempt from user fees for mental health services, while 18% (n=7/38) stated they do not offer fee exemptions *(14)*.

Discussion

Summary of findings

The findings show that the prevalence of CAYMH conditions is increasing over time, females are more likely to be impacted by mental health conditions, suicide is the leading cause of death for those aged 15–29 years old and males are more likely to die by suicide. Adolescent mental health and well-being outcomes have also declined since 2018. Environments are not adequately supporting the mental health of CAY: half of CAY experience ACEs, 20% report no social support and there is a decrease in school satisfaction over time. New challenges are arising, such as the problematic use of social media and gaming. Policies and plans for CAYMH are lacking in one fifth of countries and more information is needed on how existing legislation and multisectoral policies support CAYMH. More countries reported the existence of CAMH services in hospitals and inpatient settings, highlighting a need for more community-based services. The mental health workforce is not sufficient to meet CAMH needs. The service received by children and adolescents with mental health conditions varies greatly across the Region, including in terms of access, quality assessment and treatment received. High variability was observed across countries throughout, including in what data was reported, the numbers and types of CAMH services available, CAMH workers, treatment rates and the CAMH service received.

Discussion of limitations

There are multiple limitations of this report. Our search was restricted to data available at the Region level, meaning national and other datasets were not included. Data that was included commonly relied on self-reported data from surveys *(12,13,15–24, 26, 27)*, meaning there may be some inaccuracies in the data. None of the surveys were completed by all 53 Member States. Datasets were inconsistent in terms of what age groups' data were available, making comparisons between datasets challenging. Data was only available in binary genders, and it was not aggregated by population groups. There are many gaps in the data available, including on socioeconomic determinants *(35)*, humanitarian crises, patient safety *(36)*, self-harm and suicide attempts and the use of artificial intelligence in CAYMH.

Confirmation of existing recommendations to strengthen CAYMH care

Our findings confirm that existing directions and recommendations are relevant for the Region. These include recommended actions to enhance prevention and promotion efforts for CAYMH at all levels (i.e. governance, everyday environments, universal and targeted interventions) *(4)*, and to provide robust support to CAY requiring targeted mental health interventions, such as to develop enabling governance (e.g. multisectoral policies, legislation) and an interconnected system of CAYMH services *(6,33)*. A key finding in this report was the lack of high-quality data available for CAYMH, highlighting the need for a more comprehensive review of CAYMH data with a broader inclusion criterion (including national datasets), as well as confirming existing directions to strengthen health information systems and data quality for mental health *(37)*. To achieve these results, funding and commitment is required, confirming global calls to increase investment for mental health *(38)*.

Chapter 5

Proposed actions to improve the quality of CAYMH care

Almost all countries globally are struggling to improve mental health outcomes for CAY *(2,3)*. Hence, in addition to confirming the previously recommended actions to improve mental health outcomes for CAYMH, we argue that a new and innovative approach is required to improve the quality of CAYMH care.

A key finding from this report was the variability and inconsistency in services available and provided for CAYMH. Inspiration can be taken from the field of QoC, which has demonstrated how to improve and standardize care quality and patient safety across various health systems and conditions *(39)*. Yet, there has been no systematic application of QoC to mental health or CAYMH, with initiatives only seen across a few high-income countries globally *(40)*.

Based on learnings from the field of QoC, there are nine proposed actions to improve the quality of CAYMH care in the Region.

1. Develop and coordinate national action plans, policies and legislation to improve the quality of CAYMH care

Improving governance for high-quality care has been recommended in the wider field of QoC *(41)*. However, efforts so far to strengthen governance for QoC have been happening mostly in isolation to efforts to strengthen governance for mental health *(42)*. The need to strengthen policies and legislation for CAYMH care was highlighted by findings in this report.

Integrating efforts to strengthen governance for the wider field of QoC with CAYMH and across multiple sectors will enable actions to improve care quality across the whole ecosystem. Elements of a QoC strategy, such as the vision, regulation, improvement methods, governance and structure for quality and monitoring *(39)* can include aspects related to CAYMH (e.g. quality indicators for CAYMH); and improving QoC for CAYMH can be included as a cross-cutting theme in multisectoral strategies, policies and legislation.

2. Incorporate incentives, including financing tools to complement quality improvement and innovation for CAYMH

Health financing mechanisms and tools can be leveraged to support continuous quality improvement for CAYMH. This review showed inconsistencies in user fees, treatment provided, the availability of facilities and availability of CAYMH health-care workers across the Region.

Financing mechanisms can reduce out-of-pocket payments for users of services, increase the availability of services and the health-care workforce and support innovation. Financing tools can be used to encourage quality improvement, for example, through rewarding high-quality care aligned with standards (e.g. coordination of care) and guidelines (e.g. treatment) and penalizing care that does not meet these standards *(39)*. For CAYMH, incentives can be used to reward workers and services across the care continuum and multiple sectors that adhere to standards and guidelines. Financing mechanisms can be leveraged to reduce user fees for accessing CAYMH care, increase the availability and quality of CAYMH facilities and the workforce, where indicated, as well as to promote innovation.

3. Set quality standards, protocols and clinical guidelines for CAYMH

Evidence-based quality standards, guidelines and protocols can define high-quality care and reduce inequities and inconsistencies in care *(39)*. Clinical pathways can determine efficient user journeys through the system. Audits, incentives and digital technologies can support their implementation.

For CAYMH, these tools provide the opportunity to reduce care inconsistencies across the continuum of care. Having a shared vision for high-quality care is the first step. To start this process, the WHO Regional Office for Europe has developed quality standards for CAYMH services *(34)* (Box 1).

Box 1. Spotlight: Quality standards for child and youth mental health services: for use in specialized community or outpatient care across the WHO European Region

Developed in collaboration with a wide range of stakeholders, the quality standards define high-quality care in CAY outpatient/community mental health services as follows:

- Users are empowered to actively participate in the design and delivery of services.
- Care upholds human rights and is safe.
- The service engages family and communities.
- The service enables smooth transitions to other services.
- The service provides timely support.
- Care is developmentally appropriate and evidence-based.
- Care is delivered by a competent and appropriate workforce.
- Care is delivered within a culture of quality improvement and data collection.

Source: (34).

4. Embed continuous quality improvement across systems and support for CAYMH

Continuous quality improvement processes are implemented with a culture of support, non-judgement, learning, problem-solving, improvement and innovation. They tend to follow similar cycles: (a) define area for improvement, desired outcome and team; (b) create ideas and agree on strategies to reach the desired outcome; (c) implement strategies; (d) iteratively monitor the outcome; and (e) adapt and go through the cycle again as needed. It is recommended for all levels of the system to be involved with an emphasis on strong team collaboration *(39)*.

Applying continuous quality improvement processes and strategies to CAYMH provides a structure to develop and test out new strategies to better meet the mental health needs of CAY. Continuous quality improvement can be applied to any area across the care continuum and/or across sectors for CAYMH. High-quality data is needed to provide baseline measures and assess the impact of initiatives. See Box 2 for a proposed process to improve the quality of CAYMH services using *Quality Standards for Child and Youth Mental Health Services (34)*.

Box 2. Spotlight: Proposed process to improve QoC CAYMH

The WHO Regional Office for Europe, in collaboration with four pilot countries and implementation scientists, has proposed the steps below to improve QoC aligned with the *Quality Standards for Child and Youth Mental Health Services (35)*.

1. Establish a working group, ideally with the involvement of users.
2. Determine which setting to implement quality standards and conduct a situation analysis if needed.
3. Use the self-assessment tool to prioritize standards for quality improvement
4. Determine the expected goal.
5. Choose quality improvement actions and measurements.
6. Implement quality improvement.
7. Evaluate the process, update quality improvement methods as needed and provide feedback.

5. Re-design service models and delivery around the needs and preferences of children, young people and their caregivers

This report found that services and support for CAY across the continuum of care could be better leveraged to strengthen CAYMH outcomes. Health service delivery and models can be used to maximize health outcomes *(41)*.

Re-designing services and testing new models of care that focus on CAYMH outcomes provides an opportunity to develop services that are delivered in places and ways that CAY will want to access them. Examples could include community "one-stop" youth centres, which integrate social, education and mental health care; youth-friendly spaces in communities that promote and protect mental health; services which are co-developed with young people; and digital technologies that allow CAY to access psychological support whenever they need it.

6. Deeply engage and empower children, young people, their families and communities

To deliver high-quality care, it is recommended to engage citizens, CAY in all aspects of service planning and delivery across the whole health system. This enables health systems to meet the needs of the communities and for communities to seek high-quality care and hold systems accountable *(39, 41)*.

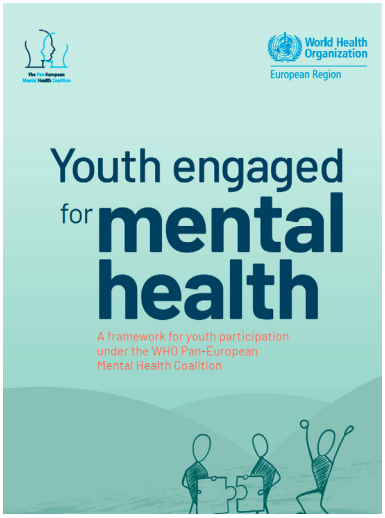
For CAYMH, user engagement and empowerment provide a way to develop strategies and support that are truly embedded in the context and preferences of CAY, allowing for better fulfilment of their mental health needs across the care continuum *(43, 44)*. This is particularly important for CAYMH given the high levels of stigma and challenges to accessing care.

It is advised to involve CAY in all decisions that affect their mental health, including: the design of governance, youth participation strategies (see Box 3 for an example *(45)*) and service model planning; how to make daily environments more supportive and how to better coordinate across sectors; and in the delivery of mental health care, quality improvement initiatives and research and data collection. Training for CAY and their communities can support self-management and the identification and referral of people requiring support.

Box 3. Spotlight: Framework for youth participation in the WHO Regional Office for Europe's work on CAYMH

Young members of the WHO Pan-European Mental Health Coalition set out a framework for their active participation. They stated that their participation should be underpinned by five guiding principles: engaging, empowering, safe and supportive, transparent and diverse, inclusive accessible.

Source: (45).



7. Invest in a CAYMH workforce that can meet the demands and needs of the population

This report showed large variations in the numbers and types of health workers for CAYMH across the Region. The QoC depends on the people working in the system. People provide higher quality care when they are motivated, supported, have the right skills mix, can work effectively together and in an enabling environment (including political, cultural and financial conditions) *(39, 42)*. Competency-based approaches to clinical education can improve care quality, with a focus on ethics and respectful care *(41)*.

Having workers with the right skill and competency mix is needed to provide a range of evidence-based interventions *(34)*. Human resources for CAYMH include not just frontline health workers, but also communities, teachers, families and caregivers and young people themselves. Hence, efforts can focus on strengthening capacity in human resources across the care continuum and in multiple sectors.

8. Measure mental health outcomes that matter to children, young people and families

This report showed that data at a regional level for CAYMH is sparse. Data was predominantly available on structures (e.g. number of services, number of facilities), with little information available on the implementation of services and no information about how CAY and families experience the care. To improve care quality, it is recommended for health information systems to measure what matters most to CAY and families; for example, user experience, confidence in the system and health outcomes *(39, 41)*.

For CAYMH, re-orienting data collection to focus on outcomes that matter most to CAY and their caregivers would allow for a better understanding of what is needed to develop services that are shaped around what is most important to them. Any proposed outcomes would need to be easy to collect, agreed by countries across the Region, kept to a minimum and supported by health information systems.

9. Research and share lessons on what works to improve the quality of CAYMH

There are large gaps in data regarding CAYMH across the Region, including what services are available, health workers available and on the QoC provided. Research is also needed to understand what works and what does not work to move health services from low quality to high quality *(41)*. This is echoed by others who call for more research in quality improvement strategies for CAYMH *(40)*.

Collaborative research and the sharing of lessons can support the scale-up of successful innovations and reduce the duplication of unsuccessful efforts. Borrowing lessons from other fields, such as implementation science and design thinking, can help to rapidly implement and evaluate initiatives. Nurturing a culture of non-judgement, learning and problem-solving can help to promote cross-country collaboration.

Possible actions for different levels of the system

Possible actions have been divided into different levels of the system and can be seen in Table 14 below.

Table 14. Possible actions to improve quality of CAYMH care across different levels of the system

Level of the system	Possible actions
WHO Regional Office for Europe	• Provide technical support to implement initiatives to improve QoC for CAYMH (e.g. QoC and CAYMH policies, strategies and legislation; financing mechanisms; quality standards, guidelines and protocols; safe regulation of medication; a culture of quality improvement; re-orienting service models to meet the needs of users; engaging and empowering CAY and communities; capacity-building; data collection; and improving staff well-being). • Collate evidence related to QoC and CAYMH, including on financing mechanisms, methods for quality improvement, service models and delivery methods, empowering CAY and communities and strengthening the workforce. • Set up a platform for sharing international learnings. • Build capacity across the Region for quality improvement actions in CAYMH. • Develop technical products to support quality improvement for CAYMH (e.g. quality standards, guidelines and protocols; guidance on how to engage with CAY and communities; and measuring outcomes). • Actively engage with CAY and communities to support WHO's work on quality of CAYMH care. • Bolster regional-level efforts for data collection through re-orienting towards outcomes that matter to CAY, and conduct a review of national level datasets.
Government (Ministries such as those with responsibilities for health, education, social affairs, disabilities, housing, urban affairs, justice, family and youth, culture and innovation)	• Develop enabling governance for high-quality CAYMH care. • Develop coordinated ways of working between sectors for integrated governance and actions to improve CAYMH outcomes. • Develop a financing structure which reduces out-of-pocket payments, allows for high-quality facilities and workforce for CAYMH and allows for testing of new ideas (e.g. bidding process for innovative ideas), and introduce incentives to reward good-quality care that meets standards and guidelines. • Set an enabling environment for high-quality CAYMH care, including a vision for high-quality CAYMH care, strengthened ability for research and data collection, re-orientation towards maximizing health outcomes rather than simply access for CAYMH and capacity for active participation from CAY in service development. • Set regulations and requirements for CAYMH workforce in collaboration with professional bodies (e.g. registration, licensing). • Support the development and implementation of strategies to improve the quality of CAYMH care, including: evidence-based treatment guidelines, protocols and quality standards; enhancing staff well-being; continuing professional development; and the setup of effective electronic health information systems for effective data collection. • Attend international initiatives and collaborations to share lessons with other countries or build capacity (e.g. on data collection, cross-country comparisons and quality improvement).

Level of the system	Possible actions
Health care, community and educational facilities	• Implement strategies to improve the quality of CAYMH care, including the following: actions from policies and legislation; evidence-based guidance from clinical guidelines protocols, standards and regulation of medicine; outreach work to engage with communities; strategies to gather user feedback (e.g. patient-reported experience measures); and work with other sectors to meet the holistic needs of CAY. • Set up a robust data collection system, which allows for efficient reporting (e.g. of patient reported outcome measures). • Build capacity among staff for high-quality CAYMH care; for example, on how to implement clinical standards and guidelines. • Set up a community of practice for inter-institutional learning. • Allow for flexibility and responsiveness in the delivery of care, so that the service model can be adapted based on the needs of users. • Actively engage young CAY in all decisions that affect them, including service models, hiring of staff and their treatment. • Set up mechanisms to measure and report on outcomes and report to the public on outcomes, for transparency and accountability. • Research and share lessons learned on strategies to improve the quality of CAYMH care.
Clinical providers	• Keep informed about and adhere to relevant strategic documents (e.g. policies, legislation, quality standards, treatment guidelines). • Collect data as needed, including on patient-reported outcome measures and patient reported experience measures. • Implement strategies to improve QoC (e.g. quality standards, guidelines, safety protocols, adverse event reporting). • Build capacity in other sectors on initiatives related to QoC and CAYMH (e.g. refining referral pathways). • Register with accreditation bodies and attend supervision and peer support group. • Research and share lessons learned on strategies to improve the quality of CAYMH care.
CAY, caregivers and public	• Mobilize action for high-quality CAYMH care, including advocating for financial systems that reduce out-of-pocket payments and appropriate staffing, and implement quality standards, protocols and guidelines. • Actively participate, through representative organizations or governmental mechanisms, in all decisions that affect CAY, including those for the development of policies, legislation, strategies, quality improvement cycles and new service models. • Participate in training and education on mental health awareness and how to participate in making health decisions. • Actively engage in the development and improvement of CAYMH outcomes and research initiatives (e.g. through youth advisory boards).

Chapter 6

Summary

This report aimed to review existing data on CAYMH available across the Region. Findings suggest gaps in the availability of data, with existing data relying on self-reports and often being inconsistent. However, findings suggest large variations across the Region in the provision of CAYMH care, with the number of CAY living with mental health conditions increasing over time. Hence there is a clear need to take a new approach to improve outcomes for CAYMH. Applying a quality-of-care lens to the field of CAYMH provides inspiration and possible actions to begin to make these improvements. Nine key actions were proposed, with possible actions from different levels of the health system. To truly improve mental health outcomes for children and youth, commitment is required from different levels of the health system, multiple sectors and the whole of society. The Regional Office is ready to support countries wishing to strengthen the quality of CAYMH care.

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